09/26/13 - MFCU/ombud/HCS - gl

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505349	A. BUILDING _____ B. WING _____	09/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLAPA HARBOR HEALTH AND REHAB	1100 JACKSON STREET RAYMOND, WA 98577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This report is the result of an unannounced 10% Off hours/staggered Quality Indicator Survey conducted at Willapa Harbor Care Center on 09/16/13, 09/17/13, 09/18/13, and 09/19/13. A sample of 27 resident was selected from a census of 39. The sample included 20 current residents and the records of 7 former and/or discharged residents.

The survey was conducted by:

[redacted] BSS
[redacted] RN, BSN
[redacted] MS

RECEIVED
OCT 10 2013
DSHS/ADSA/RCS

The survey team is from:

Department of Social & Health Services
Aging & Disability Services Administration
Residential Care Services, District 3, Unit C & D
6639 Capital Boulevard SW
P.O. Box 45819
Tumwater, Washington 98501
Telephone: 360.664.8429
Fax: 360.664.8451

Residential Care Services — Date 9/24/13

Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, alleged or the correctness of any conclusion set forth in this allegation by the survey agency. Accordingly, the facility has prepare and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under the state and federal law that mandate submission of a plan of correction within 10 days of the survey as a condition to participate in Title 18 and Title 19 programs. The submission of the plan of correction within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility. This plan of correction is submitted as the facility's credible allegation of compliance.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robert Barnett	Administrator	10/4/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 154 SS=D	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: The facility failed to obtain informed consent for 2 of 6 residents (#3 & 79) reviewed for consent of psychotropic medication use. This failure placed residents at risk of experiencing medication side effects without understanding the risks and benefits of the medication. Resident #3's Minimum Data Set (MDS), an assessment tool, dated 08/02/13 indicated the resident was cognitively impaired and had a Power of Attorney (POA) for decision making. Record review indicated [redacted] an anti-anxiety medication, was physician prescribed for Resident #3 on 08/25/13. According to the resident's Medication Administration Record, the resident was given [redacted] on 08/25/13. Review of the resident's chart did not indicate that risks and benefits of the medication had been discussed with the resident's POA prior to administering the medication to the resident. On 09/19/13 at 10:03 a.m., the Director of	F 154	**483.10(b) (3), 483.10(d) (2) INFORMED OF HEALTH STATUS, CARE & TREATMENT** **F-154** Willapa Harbor Health & Rehab will continue to ensure that the resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. Resident # 3 attending physician gave an order for [redacted] to address an emergent medical issue – a critically high blood pressure. The Ativan dose accomplished the intended purpose. The blood pressure returned to normal. The Ativan was never used again. The facility did discuss the medications risks & benefits with the POA but failed to get signatures on the informed consent form to be filed with the resident's medical record and failed to document the phone conversation in the nurse's notes. However, the DNS did receive verification from the	

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F 154	Continued From page 2 Nursing Services (DNS) confirmed the resident had been given [redacted] on 08/25/13 and stated, "I may not have the consent signed yet." The DNS confirmed there was no documentation in the resident's medical chart to indicate the POA had been contacted prior to the medication being administered so the risks and benefits of the medication could be explained. Resident #79 was admitted to the facility on [redacted]13 with diagnoses to include [redacted] The resident was cognitively intact and able to make his needs known. On 7/30/13, the resident's physician ordered [redacted] (for insomnia), and [redacted] The resident received the ordered [redacted] and [redacted] on 7/30/13. On 9/19/13, the resident's medical chart was reviewed and signed informed consents for [redacted] were not found. On 9/20/13, the DNS stated all [redacted] medications must have an informed consent signed by the resident, or their representative, prior to receiving the medication. At 5:30 p.m., after reviewing the resident's chart, the DNS reported she was unable to locate signed consents in the resident's chart. The DNS stated, "We did get verbal consent from him on admit but we didn't get signatures."	F 154	POA that she did receive a message regarding the incident on her phone recorder. Resident #3 continues to function at her highest practicable level. Resident # 79 was prescribed three medications that required informed consent explaining the risks & benefits. The facility failed to obtain signatures for the consent forms to be filed in the medical record. The facility did get a verbal approval as confirmed by the family; however, the form was not signed. Resident #79 was never at risk of experiencing medication side effects that were not understood. Resident #79 has been followed by Willapa [redacted] and has been taking these three [redacted] medications. No other residents have been effected by this deficient practice.	

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F 154	Continued From page 3 SEE WORKING PAPERS	F 154	Licensed nurses have received inservice education by the director of staff education on the policy & procedure for obtaining and filing the written informed consent for the medications requiring an explanation of their risks and benefits. The resident was monitored every shift for side effects for all of the medications that he took. Through rehabilitation, and stabilizing his clinical condition he was able to achieve his highest practicable level and discharge safely to his home. Monitoring will be provided by the DNS, Medical Records Designee, & Nursing Supervisors as required. Monthly the DNS will report any deficient practices to the CQI Committee for their review and recommendations. COMPLETION DATE	10/11/13
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		

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F 157	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to notify a resident's Power of Attorney for 1 of 5 residents (#3) reviewed for notification of change. This failure excluded the Power of Attorney (POA) from receiving notification of the resident's change in behavior. Resident #3 was admitted to the facility on [redacted]11 with diagnosis to include [redacted] According to the resident's Minimum Data Set (MDS), an assessment tool, dated 08/22/13, the resident was identified to be cognitively impaired and had a Power of Attorney for decision making. According to the resident's medical chart, on 08/25/13 the resident was observed by a licensed nurse (LN) having a panicked look on her face. The chart notes indicated the resident stated, "I'm just really scared." The resident did not know staff or where she was. The resident's blood pressure was taken and recorded as 230/120, a reading that was higher than the resident's baseline blood pressure, and was verified by a second LN. Chart notes indicated the resident's physician was notified regarding the change in condition. [redacted] medication was prescribed and administered to Resident #3. One hour later, the resident was found in the nursing station flipping through a binder stating, "I need to find help to get out of here. I want to leave."	F 157	**483.10(b) (11)** **NOTIFY OF CHANGES OF CONDITION** **F-157** Willapa Harbor Health & Rehab will immediately inform the resident, consult the attending physician and notify the responsible party in the event of a change in condition of the resident. Resident # 3's attending physician gave an order for [redacted] to address her abnormally high blood pressure. The facility did discuss the medications risks & benefits and her abnormally high blood pressure and change of behavior with the POA but failed document the conversation. The DNS did receive verification from the POA that she did receive a message regarding the incident on her phone recorder. Resident #3 continues to function at her highest practicable level.	

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F 157	Continued From page 5 There was no documentation in the medical chart that the resident's POA had been contacted regarding the resident's change in condition or informed of the risks and benefits of the new medication. On 09/19/13 at 10:10 a.m., when asked if the resident's POA was notified of the change, the Director of Nursing Services confirmed she could not find documentation in the chart that the POA had been notified of the resident's change in condition.	F 157	Licensed nurses have received inservice education by the director of staff education on the policy & procedure for notification of change of condition of the resident and the appropriate documentation in the resident's medical record. No other residents were affected by this deficient practice. Monitoring will be provided by the DNS, Director of Staff Education, & Nursing Supervisors as required. Monthly the DNS will report any deficient practices to the CQI Committee for their review and recommendations. COMPLETION DATE **483.20(D), 483.20(K) (1) DEVELOP COMPREHENSIVE CARE PLANS** F-279 Willapa Harbor Health & Rehab	10/11/13
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		

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F 279	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to develop a comprehensive care plan to address identified dental needs for 1 of 3 residents (#76) reviewed for dental care plans. This failure placed the resident at risk of not attaining his/her highest practicable well-being and placed the resident at risk of chewing problems and discomfort. The resident's Minimum Data Set (MDS), an assessment tool, dated 08/26/13, indicated Resident #76 was assessed to have the following dental issues: broken or loosely fitting full or partial dentures and mouth or facial pain, discomfort or difficulty with chewing. The resident's MDS identified these dental issues on assessments dated 08/12/13 and 08/05/13 and the initial admission nursing assessment indicated the resident's teeth were in poor condition. Resident #76's comprehensive care plan was reviewed. Although dental issues had been identified and assessed, the resident's care plan did not address the resident's dental issues. On 09/17/2013 11:06 a.m., the resident indicated a concern with chewing and eating problems. The resident was observed by the surveyor to have multiple missing teeth. On 09/18/13 at 10:31 a.m., when asked about a	F 279	will continue to use the results of the resident assessment to develop, review and revise the resident's comprehensive plan of care. We will continue to attain, and/or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Resident # 76 was admitted to the facility with multiple health problems that were not compatible with life. One of the issues that were assessed by the licensed staff was her oral condition. The resident denied any pain or problems with chewing. When asked, she did not want to see a dentist. The resident stated that she has her own dentist in Westport that she can see if chooses to. The facility did not address her dental condition in her plan of care because the resident denied any oral pain or difficulties chewing. The resident has completed her rehab and has returned to her prior independence and will be	

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F 279	Continued From page 7 dental plan of care for Resident #76, the Director of Nursing Services stated they had focused on other needs of the resident and did not address the dental issue.	F 279	discharged to the community. No other residents were effected by this deficient practice.	
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to arrange dental services for 1 of 3 residents (#76) reviewed for dental needs. This failure placed the resident at risk of not attaining his/her highest practicable level of well-being and placed the resident at risk of chewing problems and discomfort. The resident's Minimum Data Set (MDS), an assessment tool, dated 08/26/13 indicated	F 411	Licensed staff were provided inservice education by the Director of Staff Education on consistently following the facility's policy and procedures for the development of a comprehensive plan of care based upon the nursing assessment of the resident. Monitoring will be provided by the DNS, Director of Staff Education, & MDS Nurse as required. Monthly the DNS will report any deficient practices to the CQI Committee for their review and recommendations. COMPLETION DATE	10/11/13

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F 411	Continued From page 8 Resident #76 was assessed to have the following dental issues: broken or loosely fitting full or partial dentures and mouth or facial pain, discomfort or difficulty with chewing. The resident's MDS identified these dental issues on assessments dated 08/12/13 and 08/05/13 and the initial admission nursing assessment indicated the resident's teeth were in poor condition. Review of the resident's medical record did not indicate the facility had attempted to refer the resident for dental care. On 09/17/2013 11:06 a.m., the resident indicated a concern with chewing and eating problems. The resident was observed by the surveyor to have multiple missing teeth. On 09/18/13 at 4:10 p.m., the Social Services Director (SSD) stated, "Nursing assesses to see if there is a need. If a resident required dental services, they (nursing) would let me know." The SSD stated if a dental appointment was needed, the Director of Nursing Services (DNS) would schedule the appointment and social services would help with transportation. When asked if a dental appointment had been made for Resident #76, the SSD stated, "We don't have anything in the works for her. It has not come to my attention." The SSD stated the MDS Nurse would be the one to inform her of the need for a dental appointment. On 09/18/13 at 5:00 p.m., the MDS nurse stated dental needs are identified during the initial	F 411	483.55(a) ROUTINE / EMERGENCY DENTAL SERVICES IN SNFS F- 411 Willapa Harbor Health & Rehab will continue to maintain its agreement with Valley Dental to assist us in obtaining routine and 24-hour emergency dental care. Resident # 76 was admitted to the facility with multiple health problems that were not compatible with life. One of the issues assessed by the licensed staff was her oral condition. The resident denied any oral pain or problems with chewing. When asked, she did not want to see a dentist. Therefore facility did not make arrangements for the resident to be seen by the dentist. The MDS nurse and licensed staff were provided inservice education on the facilities	

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F 411	Continued From page 9 admission nursing assessment. When asked about Resident #76, The MDS nurse stated when the resident first came in she was really sick and didn't want anything done at that time. There was no documentation in the medical chart to support there had been a discussion with the resident regarding dental services. The MDS Nurse stated, "I should have went back and addressed it when she was better. That would be a good plan."	F 411	ongoing policy regarding dental assessment, care and service. If a need has been identified and the resident or the POA would like to have the consult of a dentist, arrangements will be made. The resident has completed her rehab and has returned her prior independence and will be discharged to the community. Monitoring will be provided by the DNS, Director of Staff Education, & Director of Social Services as required. Monthly the DNS will report any deficient practices to the CQI Committee for their review and recommendations. COMPLETION DATE.	10/11/13